FOR OHF USE

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027359

Facility Name: SENIOR MANOR NURSING CENTER

Address: 223 EAST FOURTH STREET (Number) SPARTA (City) 62286 (Zip Code)

County: RANDOLPH

Telephone Number: (618)443-4411 **Fax #** (618)443-2212

IDPA ID Number: 371119667001

Date of Initial License for Current Owners: 10/01/82

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ROGER BAGLEY **Telephone Number:** (618)549-8331
JAMESTOWN MGMT CORP

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) ROGER W. BAGLEY
(Title) CONTROLLER

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	20	Skilled (SNF)	20	7,300	1
2		Skilled Pediatric (SNF/PED)			2
3	39	Intermediate (ICF)	39	14,235	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	59	TOTALS	59	21,535	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	517	258	364	1,139	8
9	SNF/PED					9
10	ICF	6,990	3,609		10,599	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,507	3,867	364	11,738	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.51%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/70

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 364

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	77,355	3,013	4,461	84,829		84,829		84,829			1
2	Food Purchase		39,178		39,178	492	39,670	(135)	39,535			2
3	Housekeeping	35,569	4,459		40,028	(170)	39,858		39,858			3
4	Laundry	28,661	3,793		32,454		32,454		32,454			4
5	Heat and Other Utilities			34,180	34,180	208	34,388		34,388			5
6	Maintenance	9,496	4,950	18,180	32,626		32,626	582	33,208			6
7	Other (specify):*											7
8	**TOTAL General Services**	151,081	55,393	56,821	263,295	530	263,825	447	264,272			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	417,394	11,790	3,266	432,450	(2,925)	429,525		429,525			10
10a	Therapy	11,061		3,127	14,188		14,188		14,188			10a
11	Activities	17,096	389	2,160	19,645	(68)	19,577		19,577			11
12	Social Services			2,160	2,160		2,160		2,160			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	445,551	12,179	13,713	471,443	(2,993)	468,450		468,450			16
	C. General Administration											
17	Administrative	34,596			34,596	29,321	63,917		63,917			17
18	Directors Fees											18
19	Professional Services			88,713	88,713	(51,270)	37,443	(33,280)	4,163			19
20	Dues, Fees, Subscriptions & Promotions			4,532	4,532	116	4,648	(2,328)	2,320			20
21	Clerical & General Office Expenses	21,577	2,366	3,762	27,705	11,519	39,224	(592)	38,632			21
22	Employee Benefits & Payroll Taxes			110,964	110,964	7,221	118,185		118,185			22
23	Inservice Training & Education			178	178		178		178			23
24	Travel and Seminar			1,058	1,058	132	1,190		1,190			24
25	Other Admin. Staff Transportation					792	792		792			25
26	Insurance-Prop.Liab.Malpractice			40,047	40,047	744	40,791		40,791			26
27	Other (specify):*											27
28	**TOTAL General Administration**	56,173	2,366	249,254	307,793	(1,425)	306,368	(36,200)	270,168			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	652,805	69,938	319,788	1,042,531	(3,888)	1,038,643	(35,753)	1,002,890			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SENIOR MANOR NURSING CENTER #0027359 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			14,848	14,848	1,335	16,183	3,722	19,905			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,159	1,159		1,159	(157)	1,002			32
33	Real Estate Taxes					302	302	11,587	11,889			33
34	Rent-Facility & Grounds			14,400	14,400	2,251	16,651		16,651			34
35	Rent-Equipment & Vehicles			1,269	1,269		1,269		1,269			35
36	Other (specify):*											36
37	**TOTAL Ownership**			31,676	31,676	3,888	35,564	15,152	50,716			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		20,282	23,537	43,819		43,819		43,819			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,303	32,303		32,303		32,303			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		20,282	55,840	76,122		76,122		76,122			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	652,805	90,220	407,304	1,150,329		1,150,329	(20,601)	1,129,728			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,421	30		9
10	Interest and Other Investment Income	(5)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(135)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(134)	21		18
19	Entertainment				19
20	Contributions	(200)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,328)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	324			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (57)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(20,544)	SCHVII	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (20,544)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (20,601)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

SENIOR MANOR NURSING CENTER

ID# 0027359

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	LINE 29 DETAIL OF OTHER ELIMINATIONS	$		1
2				2
3	DEFERRED MAINT ADJUSTMENT SCHXIX-H	582	6	3
4	ELIM CONT & ACT EXP PER INCOME REC'D	(258)	21	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	324		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(135)	0	0	0	0	0	0	0	0	0	0	(135)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	582	0	0	0	0	0	0	0	0	0	0	582	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	447	0	0	0	0	0	0	0	0	0	0	447	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(33,280)	0	0	0	0	0	0	0	0	0	(33,280)	19
20	Fees, Subscriptions & Promotions	(2,328)	0	0	0	0	0	0	0	0	0	0	(2,328)	20
21	Clerical & General Office Expenses	(592)	0	0	0	0	0	0	0	0	0	0	(592)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(2,920)	(33,280)	0	0	0	0	0	0	0	0	0	(36,200)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,473)	(33,280)	0	0	0	0	0	0	0	0	0	(35,753)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number SENIOR MANOR NURSING CENTER **#** 0027359 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	2,421	1,301	0	0	0	0	0	0	0	0	0	3,722	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5)	(152)	0	0	0	0	0	0	0	0	0	(157)	32
33	Real Estate Taxes	0	11,587	0	0	0	0	0	0	0	0	0	11,587	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	2,416	12,736	0	0	0	0	0	0	0	0	0	15,152	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(57)	(20,544)	0	0	0	0	0	0	0	0	0	(20,601)	45

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LIST ATTACHED		CANTERBURY MANOR NURSING HOME	WATERLOO	JAMESTOWN MGT	CARBONDALE	NURSING HOME
		FAIR ACRES NURSING HOME	DUQUOIN	CORP.		MANAGEMENT
		FAIRVIEW NURSING HOME	DUQUOIN			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	MANAGEMENT FEES	$ 84,691	JAMESTOWN MANAGEMENT CORP	32.00%	$ 51,411	$ (33,280)	1
2	V	33	REAL ESTATE TAXES		FOURTH STREET LAND TRUST	100.00%	11,587	11,587	2
3	V	30	DEPRECIATION		FOURTH STREET LAND TRUST	100.00%	1,301	1,301	3
4	V	32	INTEREST INCOME		FOURTH STREET LAND TRUST	100.00%	(152)	(152)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 84,691			$ 64,147	$ * (20,544)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	OWNER'S COMPENSATION HAS BEEN ELIMINATED								$		1
2	PRIOR TO THE COST REPORT										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: JAMESTOWN MANAGEMENT CORP
Street Address: 1001 E. MAIN BLDG 4A
City / State / Zip Code: CARBONDALE, IL 62901
Phone Number: ((618)549-8331
Fax Number: ((618)549-0133

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	HOURS OF SERVICE	18,158		$ 5,822	$	1,548	$ 496	1
2	5	UTILITIES	HOURS OF SERVICE	18,158		2,445		1,548	208	2
3	17	ADMINISTRATIVE	HOURS OF SERVICE	11,484		343,946	343,946	979	29,321	3
4	19	LEGAL & ACCOUNTING	HOURS OF SERVICE	18,158		1,652		1,548	141	4
5	20	LICENSE AND DUES	HOURS OF SERVICE	18,158		1,355		1,548	116	5
6	21	CLERICAL SALARIES	HOURS OF SERVICE	6,674		110,867	110,867	569	9,452	6
7	21	CLERICAL & GEN OFFICE EX	HOURS OF SERVICE	18,158		9,170		1,548	782	7
8	22	EMPLOYEE BENEFITS	HOURS OF SERVICE	18,158		62,630		1,548	5,339	8
9	24	SEMINARS	HOURS OF SERVICE	11,484		1,546		979	132	9
10	25	AUTO EXPENSES	HOURS OF SERVICE	11,484		9,288		979	792	10
11	26	GENERAL INSURANCE	HOURS OF SERVICE	18,158		8,724		1,548	744	11
12	30	DEPRECIATION	HOURS OF SERVICE	18,158		15,654		1,548	1,335	12
13	33	REAL ESTATE TAXES	HOURS OF SERVICE	18,158		3,545		1,548	302	13
14	34	RENT	HOURS OF SERVICE	18,158		26,400		1,548	2,251	14
15										15
16										16
17										17
18										18
19		*** EXCESS SALARY OF RELATED INDIVIDUAL HAS BEEN								19
20		ELIMINATED PRIOR TO COST REPORT								20
21										21
22										22
23										23
24										24
25	TOTALS					$ 603,044	$ 454,813		$ 51,411	25

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	FAIR ACRES & FAIRVIEW	X		TEMP. WORKING CAPITAL	N/A					0.0600	250	6
7	BANTERRA BANK		X	WORKING CAPITAL	N/A					0.0600	909	7
8												8
9	TOTAL Facility Related						$	$			$ 1,159	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 1,159	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	11,587	2
3. Under or (over) accrual (line 2 minus line 1).	$	11,587	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	11,587	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	10,533	8
	1999	10,743	9
	2000	10,887	10
	2001	11,431	11
	2002	11,587	12

****** LINE 7 DOES NOT INCLUDE THE JAMESTOWN MANAGEMENT ALLOCATION FROM PG 8 SCH VIII OF $302. TO RECONCILE REAL ESTATE TAX EXPENSE ADD LINE 7 $11587 TO JAMESTOWN ALLOCATION OF $302= 11889 THIS IS THE AMOUNT ON PAGE 4 LINE 33

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SENIOR MANOR NURSING CENTER COUNTY RANDOLPH

FACILITY IDPH LICENSE NUMBER 0027359

CONTACT PERSON REGARDING THIS REPORT ROGER BAGLEY

TELEPHONE (618) 549-8331 FAX #: (618) 549-0133

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-148-012-00	225/868/LOT 1 FOURTH STREET	$ 11,452.74	$ 11,452.74
2.	19-148-013-00	489/963/489/965 lot 2 4th street s/d	$ 134.12	$ 134.12
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 11,586.86	$ 11,586.86

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,936 B. General Construction Type: Exterior MASONRY Frame concrete & wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	BUILDING	30,000	1970	$ 6,000	1
2					2
3	TOTALS	30,000		$ 6,000	3

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	43		1970	1970	$ 153,542	$	30	$	$	$ 153,542	4
5	16		1976	1976	51,431		25			51,431	5
6			1976	1976	38,320		15			38,320	6
7			1976	1976	7,820		20			7,820	7
8			1976	1976	45,187		25			45,187	8
	Improvement Type**										
9	FULLY DEPR (HEAT & AIR COND / NURSES STATION)			1976	30,444		10			30,444	9
10	STORAGE BUILDING			1981	1,317		15			1,317	10
11	ROOF			1982	8,430		10			8,430	11
12	ACTIVITY ROOM			1986	21,751	1,208	20	1,088	(120)	19,040	12
13	CONCRETE PORCH AND WALK			1988	3,276	73	20	164	91	2,542	13
14	BATH AND KITCHEN TILE			1989	4,377	292	20	219	(73)	3,175	14
15	REPAIR SHOWER			1989	548	37	20	27	(10)	392	15
16	4 WALL A/C UNITS			1990	4,893		10			4,893	16
17	PLUMBING			1990	4,324	137	20	216	79	2,916	17
18	PARKING LOT			1990	9,280	619	15	619		8,356	18
19	CUBICLE TRACK			1990	1,750		10			1,750	19
20	ELECTRICAL WIRING & FIXTURES			1990	963		20	48	48	648	20
21	ROOF			1991	14,388		20	719	719	8,629	21
22	PHONE SYSTEM			1991	3,243		20	162	162	2,025	22
23	ASPHALT WORK			1991	2,155	144	15	144		1,800	23
24	OFFICE REMODELING			1991	2,541	169	15	169		2,113	24
25	LANDSCAPING			1991	1,548	103	10		(103)	1,548	25
26	MORTON BUILDING			1992	1,992		20	100	100	1,150	26
27	FIRE ALARM SYSTEM			1994	3,345	335	10	335		3,182	27
28	PARKING LOT			1994	5,655	377	15	377		3,582	28
29	WATER HEATER			1996	1,680	112	15	112		840	29
30	WALL UNIT HEAT / COOL			1996	915		10	92	92	690	30
31	ARMSTRONG FLOORING IN DINNING ROOM			1997	4,976	332	10	498	166	3,237	31
32	NEW GASLINE RAN			1997	945	38	25	38		247	32
33	FIRE EXTINGUISHING SYSTEM ABOVE HOOD			1997	1,578	105	15	105		683	33
34	built cabinet, closet, & computer station in beauty shop area			1997	4,511	451	10	451		2,932	34
35	NEW FLOORING IN ROOM 102			1997	749	75	10	75		487	35
36	BACKFLOW PREVENTOR ON WATER SOFTNER			1997	601	40	15	40		260	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	1 WALL UNIT HEAT / COOL	1997	$ 924	$	10	$ 92	$ 92	$ 598	37
38	CARPETING AND WALLPAPER DOWN HALLWAYS	1998	6,904	616	10	690	74	3,795	38
39	WATER HEATER	1998	3,291	294	10	329	35	1,810	39
40	2 GE THRU WALL HEAT / AC UNITS	1998	1,807	161	10	181	20	995	40
41	WATER HEATER	1998	3,484	311	10	348	37	1,914	41
42	WATER SOFTNER	1998	1,400	125	10	140	15	770	42
43	ROOF REPAIR	1999	8,452		10	845	845	3,803	43
44	SIGN/ SEAL & STRIPE PARKING LOT	1999	2,428	269	10	269		1,211	44
45	CARRIER A/C UNIT	1999	2,900	290	10	290		1,305	45
46	new carpet, added interior window, built work top, & clinical	1999	7,602	760	10	760		3,420	46
47	record storage, built water heater surround wall all in								47
48	nurses office / station								48
49	labor & materials for new sink, flooring, and lighting in	1999	1,164	116	10	116		522	49
50	private pay room								50
51	tore out existing wood floor, laid tile on concrete, and	1999	4,683	468	10	468		2,106	51
52	wallpapered in the kozy knook and dining room								52
53	remove wallpaper, repaired walls, cut off door, new cove	1999	376	38	10	38		171	53
54	base in all the adminstrator's office								54
55	LIGHT FIXTURES PUT DOWN HALLWAYS	1999	435	44	10	44		198	55
56	TILE & COVE BASE IN KOZY KNOOK	2000	1,729	173	10	173		605	56
57	remove & replace damaged asphalt in parking lot	2001	1,900	127	8	238	111	595	57
58	remove & replace old vinyl perimeter of dining rrom	2001	1,735	174	10	174		435	58
59	OVERBED LIGHTS & INSTALLATION	2002	2,193	219	10	219		329	59
60	REPAIR OF FIRE SPRINKLER SYSTEM	2003	9,956	498	10	498		498	60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 501,838	$ 9,330		$ 11,710	$ 2,380	$ 438,688	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 62,578	$ 5,440	$ 6,833	$ 1,393	VARIOUS	$ 38,282	71
72	Current Year Purchases	549	78	27	(51)	10	27	72
73	Fully Depreciated Assets	152,191				VARIOUS	152,191	73
74								74
75	TOTALS	$ 215,318	$ 5,518	$ 6,860	$ 1,342		$ 190,500	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	JAMESTOWN ALLOCATION			$	$ 1,335	$ 1,335	$		$ 5,555	76
77										77
78										78
79										79
80	TOTALS			$	$ 1,335	$ 1,335	$		$ 5,555	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 723,156	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 16,183	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 19,905	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,722	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 634,743	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 1,269 Description: DISHWASHER(828) STORAGE(114) WATER SOFTNER(327)
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   we only hire trained aides

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39/3	hrs	$	119	$ 8,421	$	119	$ 8,421	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		27	2,298		27	2,298	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3;39/2	hrs		175	12,271	138	175	12,409	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/2	# of prescrpts				15,054		15,054	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	oxygen, tubefeeding, medical supplies Other (specify): labs	39/2 39/3				547	5,090		5,637	13
14	TOTAL			$	321	$ 23,537	$ 20,282	321	$ 43,819	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 40,735	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	85,425		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	12,426		5
6	Prepaid Insurance	(18,379)		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 120,207	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	127,443		15
16	Equipment, at Historical Cost	147,586		16
17	Accumulated Depreciation (book methods)	(220,318)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 54,711	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 174,918	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 20,541	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	8,279		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,696		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	LOAN FROM OWNERS	185,000		36
37	401K LIABILITY	5,662		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 227,178	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 227,178	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (52,260)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 174,918	$	48

***(See instructions.)**

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 35,993	1
2	Restatements (describe):		2
3	2002 TAXES RECORDED	3,044	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 39,037	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(91,297)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (91,297)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (52,260)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 999,881	1
2	Discounts and Allowances for all Levels	16,650	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,016,531	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	38,700	6
7	Oxygen	3,093	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 41,793	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	703	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 703	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,059,032	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	263,295	31
32	Health Care	471,443	32
33	General Administration	307,793	33
	B. Capital Expense		
34	Ownership	31,676	34
	C. Ancillary Expense		
35	Special Cost Centers	43,819	35
36	Provider Participation Fee	32,303	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,150,329	40
41	**Income before Income Taxes (line 30 minus line 40)****	(91,297)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (91,297)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,852	2,076	$ 39,045	$ 18.81	1
2	Assistant Director of Nursing					2
3	Registered Nurses	90	90	1,661	18.46	3
4	Licensed Practical Nurses	10,929	11,669	149,447	12.81	4
5	Nurse Aides & Orderlies	25,576	27,492	227,241	8.27	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,326	1,389	11,061	7.96	8
9	Activity Director	1,882	2,075	17,096	8.24	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,114	2,257	20,953	9.28	14
15	Cook Helpers/Assistants	7,031	7,940	56,402	7.10	15
16	Dishwashers					16
17	Maintenance Workers	997	1,029	9,496	9.23	17
18	Housekeepers	4,257	4,686	35,569	7.59	18
19	Laundry	3,007	3,231	28,661	8.87	19
20	Administrator	1,828	2,080	34,596	16.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,927	2,086	21,577	10.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	62,816	68,100	$ 652,805 *	$ 9.59	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	92	$ 4,461	1/3	35
36	Medical Director		3,000	9/3	36
37	Medical Records Consultant	30	1,694	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	600	10/3	39
40	Physical Therapy Consultant	50	2,933	10A/3	40
41	Occupational Therapy Consultant	2	102	10A/3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	92	10A/3	43
44	Activity Consultant	42	2,160	11/3	44
45	Social Service Consultant	42	2,160	12/3	45
46	Other(specify)				46
47	PURCHASING CONS.		549	19/3	47
48					48
49	TOTAL (lines 35 - 48)	307	$ 17,751		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	8	219	10/3	51
52	Nurse Aides	42	753	10/3	52
53	TOTAL (lines 50 - 52)	50	$ 972		53

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
PAULA MUNSEN	AMINISTRATOR	0	$ 34,596
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 34,596

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
JAMESTOWN MGMT	MANAGEMENT	$ 84,691
MIKRON	COMPUTER	900
ADP	PAYROLL	552
M. E. S.	PURCHASING CONS	549
BARNETT & LEVINE	ACCOUNTING	1,260
BENEFIT PLANNING CONS.	401K SERVICES	761
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 88,713

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 35,112
Unemployment Compensation Insurance	9,074
FICA Taxes	49,940
Employee Health Insurance	5,230
Employee Meals	1,882
Illinois Municipal Retirement Fund (IMRF)*	
401K CONTRIBUTIONS	5,336
VACCINES	1,339
JAMESTOWN ALLOCATION	5,339
PARTIES, MERIT, ATTENDANCE, ECT.	4,933
TOTAL (agree to Schedule V, line 22, col.8)	$ 118,185

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	906
Health Care Worker Background Check	
(Indicate # of checks performed 29)	350
OTHER ADV (2328) (ELIM)	2,328
franch tx(50) foreign corp fee(50)	100
stat repr(285) INHAA(100)	385
LTC DON (30) subscriptions(233)	263
JAMESTOWN ALLOCATION	116
Less: Public Relations Expense	( )
Non-allowable advertising	(2,328)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,320

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	285
JAMESTOWN ALLOCATION	132
Seminar Expense	773
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,190

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING	1999	$ 1,768	3	$ 589	$ 589	$ 295	$	$	$	$	$	$
2	PAINTING	2002	1,745	3			291	582	582	290			
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 3,513		$ 589	$ 589	$ 586	$ 582	$ 582	$ 290	$	$	$

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **32,303**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **1,882** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

SENIOR MANOR NURSING CENTER INC.
RECL FOR PAGES 3 & 4 COLUMN 5 DPA COST REPORT
12/31/2003
ID # 0027359

LINE #	ACCOUNT TITLE DESCRIPTION	DEBIT	CREDIT
22	EMPLOYEE BENEFITS	1882	
2	FOOD PURCHASES		1882
	RECL EMPLOYEE MEALS		
10	NURSING & MEDICAL RECORDS	666	
3	HOUSEKEEPING		666
	RECL SOAP & SHAMPOO		
21	CLERICAL & GENERAL OFFICE EXPENSE	1285	
10	NURSING & MEDICAL RECORDS		1285
	RECL OFFICES SUPPLIES		
2	FOOD PURCHASES	68	
11	ACTIVITIES		68
	RECL FOOD USED IN ACTIVITIES		
2	FOOD PURCHASES	2306	
10	NURSING & MEDICAL RECORDS		2306
	RECL FOOD SUPPLEMENTS		
VARIOUS	VARIOUS LINE ITEMS	51411	
19	PROFESSIONAL SERVICES		51411
	FOR BREAKDOWN SEE SCHVIII		